STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155478	A. BUILDING 01 B. WING	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERS OF JASPER THE	2909 HOWARD DR JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/11/12 Facility Number: 000314 Provider Number: 155478 AIM Number: 100274210 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, The Timbers of Jasper was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review on or after	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, and battery operated smoke detectors in all resident rooms. The facility has a capacity of 76 and had a census of 72 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/12/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 8 emergency exit doors which was provided with a delayed egress locking device connected to the fire alarm system, had adequate provisions made for the rapid removal of occupants by means such as a keypad unlocking device, a remote unlocking device, or keying of the locked doors with keys carried by all staff at all times. LSC Section 19.2.1 refers to LSC Chapter 7. LSC 7.2.1.6.1 requires buildings protected throughout by an approved supervised automatic fire alarm system may have doors equipped with approved, listed, delayed-egress locks which shall automatically unlock upon actuation of an approved supervised automatic fire alarm system installed in accordance with Section 9.6. This deficient practice could affect 27 residents, as well as staff and visitors in 400 hall.	K0038	The facility's intent is to ensure exit access is arranged so that exits are readily accessible at all times. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice 1. The Maintenance Director contacted the licensed contractor immediately following survey. On 4/12/12, the vendor completed the repair and tested. The door released properly when fire alarm activated. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken 1. No other doors were identified. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur 1.The Maintenance Director will check the door release during the monthly fire drills to ensure proper working order. The Maintenance Director will document findings on fire drill report. Any findings needing repair, the Maintenance Director/Designee will immediately contact to have the contracted vendor complete	04/12/2012

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	Findings include: Based on observation on 04/11/12 at 11:35 a.m. while testing the fire alarm system during a tour of the facility with the Maintenance Director, the 400 hall exit door was locked against egress and equipped with a delayed egress locking device (magnetic lock). The only way to exit this door was to push on the door for 15 seconds, actuate the fire alarm system or press a five digit code on the keypad. When the fire alarm system was actuated, this exit door did not release from the magnetic lock automatically. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)		repair. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place 1. The Executive Director/Designee will review monthly fire drill reports for documentation of release of doors operation during test. 2.To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the fire drill report and results of these reviews will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.	